

## **Georgia Board of Nursing – Licensure By Reinstatement as a Registered Nurse / Advanced Practice Registered Nurse**

**Please follow these easy steps to ensure that your application is processed as quickly as possible.**

1. Complete the application in its entirety. Indicate N/A for any blanks that are not applicable.
2. Include a check or money order payable to the Professional Licensing Boards in the amount of \$90.00 for each reinstatement request (RN/APRN). Please note that application fees are non-refundable.
3. Board rule 410-8-.01 requires applicants for licensure by reinstatement to document one of the following: 1) Graduation from a nursing education program within four years of the date of application; or 2) Five hundred (500) hours of practice as a registered nurse / advanced practice registered nurse (based on the definition of the "Practice of Nursing" found in O.C.G.A. §43-26-3) within the four years preceding the date of this application. Have your employer complete the attached "Verification of Employment Form" to provide documentation of active practice within the four years preceding the date of this application. To avoid processing delays please submit verifications of employment as part of your application packet.
6. The Board requires applicants to disclose all previous arrests, history of treatment for substance abuse or dependence and discipline by other regulatory boards. If you have ever been arrested, received treatment, or been disciplined by any other regulatory board or agency please provide a certified copy of the official documents showing the final disposition or order relevant to the incident as well as a personal, detailed letter of explanation regarding each incident. If you are required to submit treatment information please include all information relevant to your diagnosis, prognosis, treatment plan, practice recommendations and discharge summary. To avoid processing delays please submit all documentation as part of your application packet.
7. Georgia law requires applicants to submit secure and verifiable documentation regarding their United States citizenship status. Submit a copy of your driver's license, United States passport or other document as indicated on page 13 of the application packet. To avoid processing delays please submit the required documentation as part of your application packet.
8. Have your completed and signed application notarized.
9. Georgia law requires applicants for licensure to complete a criminal background check. Please visit the Board's website at [www.sos.ga.gov/plb/rn](http://www.sos.ga.gov/plb/rn), click on "Application Downloads" and view the instructions for completing a criminal background check by fingerprinting. Please note that the ORI/OAC for the Georgia Board of Nursing is GA922931Z and the verification code is 922931Z.
10. Submit your completed application to the Professional Licensing Boards for processing. Applications are processed in the order in which they are received. To avoid processing delays please be sure to include all required documentation with your application packet. Applications are valid for one year from the date of submission. When mailing your application please use a 9x12 envelope and do not fold or staple any of the documents.

You must not engage in registered nursing practice in Georgia until you are licensed by the Georgia Board of Nursing. Any person practicing or offering to practice nursing or using the title "registered professional nurse," as defined in O.C.G.A. §§ 43-26-1 et.seq. within the State of Georgia, shall be licensed as provided in O.C.G.A. §§ 43-26-1 et.seq.

**FOR BOARD USE ONLY**

Amount Submitted \_\_\_\_\_

Date \_\_\_\_\_

Receipt # \_\_\_\_\_



**FOR BOARD USE ONLY**

Certificate Number \_\_\_\_\_

Date Issued \_\_\_\_\_

Applicant No. \_\_\_\_\_

**GEORGIA BOARD OF NURSING**  
 237 Coliseum Drive • Macon, Georgia 31217 • (478) 207-2440  
[www.sos.ga.gov/plb/rn](http://www.sos.ga.gov/plb/rn)

**APPLICATION FOR REINSTATMENT OF LICENSURE AS A REGISTERED NURSE and/or  
 REINSTATEMENT OF AUTHORIZATION AS AN ADVANCED PRACTICE REGISTERED NURSE**  
**Application Fee \$90.00 (non-refundable)**

\_\_\_\_\_ Reinstatement RN: Application Fee \$90 (non-refundable) License# RN \_\_\_\_\_

\_\_\_\_\_ Reinstatement APRN: Application Fee \$90 (non-refundable) A separate application is necessary for each APRN title request.

\_\_\_\_\_ NP      \_\_\_\_\_ CNS-PMH      \_\_\_\_\_ CNM      \_\_\_\_\_ CNS      \_\_\_\_\_ CRNA

**1. Legal Name to  
 appear on License:**

\_\_\_\_\_ LAST                                      FIRST                                      MIDDLE                                      MAIDEN

**2. Name as shown on exam records, transcripts or any documentation provided to the Board including maiden name (if different):**

\_\_\_\_\_ LAST                                      FIRST                                      MIDDLE                                      MAIDEN

**3. Social Security #\*:**      [ ][ ] [ ][ ] - [ ][ ] - [ ][ ][ ][ ]      **Date of Birth:**      [ M ][ M ] - [ D ][ D ] - [ Y ][ Y ][ Y ][ Y ]

**4. Gender:**    ☐ Male      ☐ Female

**5. Residential (Physical)  
 Address:**

NUMBER AND STREET (P.O. BOX NOT ACCEPTABLE)

APT #

CITY

STATE

ZIP

**6. Mailing  
 Address\*:**

NUMBER AND STREET (P.O. BOX ACCEPTABLE)

APT #

CITY

STATE

ZIP

\*Pursuant to O.C.G.A. §43-1-2 (k) your name, mailing address and license number are public information and will appear on Secretary of State's website.

**7. Daytime Phone #:**      [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ][ ]      **Evening Phone #:**      [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ][ ]

**8. E-mail Address:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

\*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §19-11-1 and O.C.G.A. §20-3-295, 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

### NURSING EDUCATION INFORMATION

Name of School	City /State/Zip Code or Country
<b>RN Degree Conferred</b>	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Diploma  <input type="checkbox"/> Associate Degree  <input type="checkbox"/> BSN  <input type="checkbox"/> APRN Certificate                 </div> <div style="width: 45%;"> <input type="checkbox"/> Post Master's Certificate  <input type="checkbox"/> Master's Degree in Nursing  <input type="checkbox"/> Doctoral Degree in Nursing  <input type="checkbox"/> Post Doctoral Certificate                 </div> </div>

### ORIGINAL GEORGIA LICENSURE INFORMATION

Date of Original RN Licensure In Georgia	
Licensure Expiration Date	
Georgia License Number	

### ACTIVE PRACTICE REQUIREMENT

**9. Board rule 410-8-.01 requires that applicants document one of the following:**

**A.** I have graduated from a nursing education program within the four years preceding the date of this application:      ☐ No    Yes ☐

**B.** I have practiced as a registered nurse (based on the definition of the "Practice of Nursing" found in O.C.G.A. §43-26-3) at least five hundred (500) hours within the four years preceding the date of this application and have provided the employment information on the grid below:      ☐ No    Yes ☐

**C.** I have practiced as an advanced practice registered nurse authorized by the Georgia Board of Nursing for at least five hundred (500) hours within the four years preceding the date of this application and have provided the employment information on the grid below:      ☐ No    Yes ☐

Employer's Name/Address	Actual Workplace Location Facility Name/City/State	Position Title	Is RN Licensure Required?	Is APRN Authorizatio n Required?	Dates From - To (mo/yr)-(mo/yr)
<b>A.</b>					
<b>B.</b>					
<b>C.</b>					

**A completed verification of employment form must be submitted for each employer listed on this grid**

Any applicant practicing as a registered nurse without licensure and/or APRN authorization will be subject to Board review. The Board requires a personal, detailed, letter of explanation and detailed employment information from the employer's HR department for any RN / APRN practice in Georgia without a valid license / authorization.

Applicants who cannot document one of the above requirements will be required to complete a Georgia Board of Nursing approved reentry program. Information and guidelines regarding reentry may be found at the Board's website under "Application Downloads."

**PREVIOUS DISCIPLINARY AND CRIMINAL ARREST INFORMATION**

**10. Board Disciplinary Actions/Legal Convictions: (Answer ALL Questions)**

- A. Have you ever been arrested or convicted of a felony, misdemeanor (other than a minor traffic violation), crime involving moral turpitude, or a crime violating federal or state law relating to controlled substances or dangerous drugs? (DWI and DUI are not minor traffic violations.) For purposes of this question, a "conviction" includes a finding of verdict of guilty, plea of guilty, a plea of nolo contendere, or first offender treatment, and also includes adjudication of guilt or sentence withheld or not entered on the charge (s). **NOTE: The answer to this question is "YES" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.**

☐ No      Yes ☐

If "yes," please include a certified copy of the court records and final disposition from the court with your application. In the event the file no longer exists, you must submit documentation from the court stating that fact. Also include a personal letter of explanation regarding each incident.

- B. Have you undergone treatment for drug or alcohol abuse within the last five years? ☐ No    Yes ☐

If "Yes," submit a personal letter of explanation regarding the incident. Also include all information relevant but not limited to your diagnosis, prognosis, psychosocial history, treatment recommendations, drug screen results and discharge summary. You must pay any cost associated with the production of the documentation.

- C. Has any licensing board or agency in Georgia or any other state ever:

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| (a) Denied your application for licensure, renewal, or reinstatement?     | <input type="checkbox"/> No | Yes <input type="checkbox"/> |
| (b) Revoked, suspended, restricted, sanctioned, or probated your license? | <input type="checkbox"/> No | Yes <input type="checkbox"/> |
| (c) Requested or accepted surrender of your license?                      | <input type="checkbox"/> No | Yes <input type="checkbox"/> |
| (d) Reprimanded, fined, or disciplined you?                               | <input type="checkbox"/> No | Yes <input type="checkbox"/> |

If "yes," please include a certified copy of that board or agency's action against your license with relevant supporting documents from the board or agency with your application. Also include a personal letter of explanation regarding each incident.

Provide the name of the agency or board in the space provided.

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Name of agency or board

## NOTARIZED SIGNATURE BY APPLICANT

### 11. APPLICANT AFFIDAVIT:

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia State Board of Nursing and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

- 1) \_\_\_\_\_ I am a United States citizen 18 years of age or older. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on page 9 of the application packet.**
- 2) \_\_\_\_\_ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

Under penalties of perjury, I understand that any false or misleading information in, or in connection with my application, may be cause for denial or revocation of licensure.

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of Nursing and/or criminal prosecution.

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Applicant

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Signature of Notary Public)

My Commission Expires: \_\_\_\_\_

#### **Have you...**

- ☐ Enclosed a \$90.00 non-refundable application fee for each reinstatement request (RN / APRN)?
- ☐ Provided employment information?
- ☐ Answered each question?
- ☐ Provided secure and verifiable documentation regarding United States citizenship?
- ☐ Have you registered with Cogent Systems for a criminal background check?

#### **Mail to:**

Georgia Board of Nursing  
237 Coliseum Drive  
Macon, Georgia 31217

## PART II

PLEASE COMPLETE THIS SECTION FOR REINSTATEMENT OF ADVANCED NURSING PRACTICE AUTHORIZATION (CNM, NP, CRNA CNS, or CNS/PMH) IN ADDITION TO PART I.

A **nonrefundable** application fee of \$90.00 is required for reinstatement of advanced nursing practice authorization.

Indicate for which of the following you are applying (check only one per application):

- ☐ Certified registered nurse anesthetist
- ☐ Certified nurse-midwife
- ☐ Nurse Practitioner \_\_\_\_\_  
Specify Type
- ☐ Clinical nurse specialist \_\_\_\_\_  
Specify Type

1. Name of National Certification Board: \_\_\_\_\_

Address: \_\_\_\_\_  
Street or P.O. Box City, State Zip Code

2. National Certification Number (if applicable): \_\_\_\_\_

Complete the above information and send the attached Verification of Certification request form to your certifying board. Please request the certifying board to send the verification of certification by email to [plb-healthcare3@sos.ga.gov](mailto:plb-healthcare3@sos.ga.gov)

Have you...

- ☐ Enclosed a \$90.00 application fee for APRN authorization?
- ☐ Enclosed a separate reinstatement application for each APRN authorization requested for reinstatement?
- ☐ Answered each question?
- ☐ Requested National Certification to be sent to [PLB-Healthcare3@sos.ga.gov](mailto:PLB-Healthcare3@sos.ga.gov)?
- ☐ Have you registered with Cogent Systems for a criminal background check?

**Mail to:** Georgia Board of Nursing  
237 Coliseum Drive  
Macon, Georgia 31217

## GEORGIA BOARD OF NURSING

237 Coliseum Drive  
Macon, Georgia 31217-3858  
(478) 207-2440

### VERIFICATION OF NATIONAL CERTIFICATION AS A NURSE-MIDWIFE, NURSE PRACTITIONER, NURSE ANESTHETIST, CLINICAL NURSE SPECIALIST OR CLINICAL NURSE SPECIALIST-PSYCHIATRIC/MENTAL HEALTH

**APPLICANT:** Complete this section and forward to your national certification board. Certifications may be submitted by email from the approved certifying organization to the Georgia Board of Nursing at [plb-healthcare3@sos.ga.gov](mailto:plb-healthcare3@sos.ga.gov).

Name \_\_\_\_\_

Last

First

Middle

Maiden

Address \_\_\_\_\_

Street

City

State

Zip

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name of Advanced Practice Nursing Education Program \_\_\_\_\_

Location (city/state) \_\_\_\_\_

Date of Completion/Graduation \_\_\_\_\_

National Certification Board \_\_\_\_\_

Type of Certification \_\_\_\_\_

Certification Number (if applicable) \_\_\_\_\_

I hereby authorize the designated national certification board to furnish the information requested to the Georgia Board of Nursing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### FOR CERTIFICATION BOARD ONLY

This is to certify that the above named was issued certification \_\_\_\_\_ number to practice as a  
\_\_\_\_\_ on \_\_\_\_\_.

(State Type of Certification)

(Initial Certification Date)

Initially Certified by: \_\_\_\_\_ Examination \_\_\_\_\_ Other Evaluation (Please Explain)

Certificate/Recertification Expires: \_\_\_\_\_

BOARD SEAL

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_

Board \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_

## GEORGIA BOARD OF NURSING

237 Coliseum Drive  
Macon, Georgia 31217-3858  
(478) 207-2440

### VERIFICATION OF EMPLOYMENT BY APPLICANTS FOR LICENSURE BY REINSTATEMENT

#### Instructions:

1. Applicant: Complete Section I and sign.
2. Submit this form to your employer to verify the numbers of hours worked. List all employment (Personnel Director, Human Resources Department) that can provide verification. Ask the employer to complete this form and place it in a sealed envelope for you to submit with your application.

#### Section I (To be completed by applicant)

\*The name and address of your employer on this form must match the name and address you listed under "Employment History" on the application.

Printed Name of Applicant: \_\_\_\_\_

Last	First	Middle	Maiden
Applicant's Address: _____			
Street	City	State	Zip Code

**RELEASE:** I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Nursing. I understand this information is required as part of the application for licensure process.

Signature of Applicant \_\_\_\_\_ Applicant Phone Number (s) \_\_\_\_\_

#### APPLICANT – DO NOT WRITE BELOW THIS LINE:

#### Section II (To be completed by person verifying employment):

##### Instructions:

1. Complete Section II of this form.
2. **You must respond to all questions or this form will not be accepted by the Board office.**
3. Employment must have been for compensation.
4. Each title held with one employer requires a separate verification form completed.
5. Return the form to the applicant in a sealed envelope.

1. Name of Facility/Business/Employer: \_\_\_\_\_ Phone Number: (     ) \_\_\_\_\_

Is this a federal agency of the United States Government? ☐ No ☐ Yes

2. Physical Address of Location: \_\_\_\_\_

City	State	Zip
------	-------	-----

3. Employee's Position/Title: \_\_\_\_\_

4. Is an RN license necessary for employment in this position? ☐ No ☐ Yes

5. Is APRN authorization required for employment? ☐ No ☐ Yes

6. Identify the actual physical location where the employee practiced to include facility name, city/state if different than # 2 above or indicate same as above:

7. Employment Dates: From: \_\_\_\_\_ (mo/yr) - To: \_\_\_\_\_ (mo/yr)

Were there any periods of extended absence during employment? ☐ No ☐ Yes If "yes" please provide dates: \_\_\_\_\_

**LIST BELOW THE NUMBER OF HOURS WORKED PER YEAR AND Job Description: List below the number of hours worked per year and duties:**

Year	Hours worked	Job Description

8. Printed name and title of person verifying employment: \_\_\_\_\_

9. I hereby certify that I am a custodian of records at \_\_\_\_\_ and the information submitted on this form is a true and correct representation of this applicant's file with our institution.

10. Signature of employer representative completing this form: \_\_\_\_\_ Date \_\_\_\_\_

**Employer Representative's Signature Must Be Notarized**

Sworn to and subscribed before me this

\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
(Notary Public)

My Commission Expires: \_\_\_\_\_

(Notary Seal)

## DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS

**APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.**

### Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

\_\_\_\_\_ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_ A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_ A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

\_\_\_\_\_ A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

\_\_\_\_\_ A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

\_\_\_\_\_A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS)(Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

\_\_\_\_\_In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature) (Date)



**OFFICE OF SECRETARY OF STATE  
PROFESSIONAL LICENSING BOARDS DIVISION  
GEORGIA BOARD OF NURSING**

**237 Coliseum Drive  
Macon, Georgia 31217  
(478) 207-2440**

**CONSENT FORM**

I hereby authorize the Georgia Board of Nursing ("Board") to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

\_\_\_\_\_  
Full Name (Print)

\_\_\_\_\_  
Physical Address (P.O. Boxes NOT Accepted)

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Race

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

**One of the following must be checked:**

- ☐ This authorization is valid for 90/180/\_\_\_\_ (circle one) days from date of signature.
- ☐ I, \_\_\_\_\_ give consent to the Board to perform periodic criminal history background checks for the duration of my licensure with this state.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Special licensure provisions (check if applicable):

- \_\_\_\_ Working with mentally disabled  
\_\_\_\_ Working with elder care  
\_\_\_\_ Working with children

### **Affidavit Regarding Citizenship**

Please submit this document along with a copy of your secure and verifiable document to the Board office as indicated on the application.

Print Name: \_\_\_\_\_

#### **APPLICANT AFFIDAVIT:**

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Board for which I am applying for licensure and I agree to abide by these laws and rules.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, administered by the Professional Licensing Boards Division, the undersigned applicant also verifies one of the following with respect to his/her application for a public benefit (check one):

- 1) \_\_\_\_\_ I am a United States citizen. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or document as indicated on the Board's website.**
- 2) \_\_\_\_\_ I am not a United States citizen, but I am either a legal permanent resident of the United States or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

In making the above representations under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute. I also understand that any failure to make full and accurate disclosures may result in disciplinary action by the Board for which I am applying for licensure.

Executed in \_\_\_\_\_ (city), \_\_\_\_\_ (state).

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Printed Name of Applicant

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE

\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC My Commission Expires: